

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution – General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 11-08-04.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the majority of the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor \$460** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20 days to the date the order was deemed received as outlined on page one of this order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

The manual therapy technique (CPT code 97140-59) on 11-12-03 and the electrodiagnostic tests (CPT codes 95900, 95903, 95904 and 95861) on 12-23-03 **were found** to be medically necessary. The unspecified medicine procedures (CPT code 97139) **were not** found to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity issues were not the only issues involved in the medical dispute to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 12-8-04 the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt.

Rule 134.202(d) states reimbursement shall be the least of the (1) MAR amount as established by this rule or (2) health care provider's usual and customary charge. The following recommended reimbursements adhere to this Rule.

CPT code 99354-25 on 11-07-03 was denied with an OH – Services have been incorrectly billed with the service codes on the same day. Ingenix Encoder Pro states, "List separately in addition to code for office or other outpatient Evaluation and Management service." **Recommend reimbursement of \$125.01.**

CPT code 97140-59 on 11-07-03, 11-17-03, 11-18-03, 12-3-03, 12-18-03 was denied with a Z3 – The procedure does not represent a separately identifiable, unrelated procedure. Per rule 133.304 (c) Carrier didn't specify which service this was global to. **Recommend reimbursement of \$170.25. (\$34.05 x 5 DOS)**

CPT code 99213-25 on 11-12-03, 11-19-03 and 12-16-03 was denied as global – E&M services may be reported separately only if the patient's condition requires a significant separately identifiable evaluation and management service beyond the usual pre-service and post -service physician work. The requestor attached documentation showing that the patient's condition required a separate service. **Recommend reimbursement of \$198.57. (66.19 x 3 DOS)**

CPT code 97140-59 on 11-19-03, was denied with a ZC – A service has been billed which is mutually exclusive of the other services on the same date. Per rule 133.304 (c) Carrier didn't specify which service this was global to. **Recommend reimbursement of \$34.05.**

CPT code 98941 on 12-12-03, 12-18-03 and 12-24-03 was denied with a TK – Rule requires legible supporting documentation. The requestor did provide supporting documentation to the Insurance Carrier and to the Commission supporting this service. **Recommend reimbursement of \$99.24. (33.08 x 3 DOS)**

CPT code 97016 on 12-12-03 was denied with a TK – Rule requires legible supporting documentation. The requestor did provide supporting documentation to the Insurance Carrier and to the Commission supporting this service. **Recommend reimbursement of \$18.09.**

Regarding CPT code 97110 on 12-12-03, 12-18-03, 12-24-03, 1-2-04, 5-24-04, 6-14-04, 6-16-04, Recent review of disputes involving CPT Code 97110 by the Medical Dispute Resolution section indicate overall deficiencies in the adequacy of the documentation of this Code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one." Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division has reviewed the matters in light all of the Commission requirements for proper documentation. The MRD declines to order payment because the SOAP notes do not clearly delineate exclusive one-on-one treatment nor did the requestor identify the severity of the injury to warrant exclusive one-to-one therapy. **Reimbursement not recommended.**

CPT code 99080-73 on 12-12-03 was denied with a TK – Rule requires legible supporting documentation. The requestor did provide supporting documentation, including the 99080-73 report to the Insurance Carrier and to the Commission. **Recommend reimbursement of \$15.00.**

CPT code 98941 on 12-23-03 was denied as global – The value of this procedure is included in another procedure performed on this date. Per rule 133.304 (c) Carrier didn't specify which service this was global to. **Recommend reimbursement of \$103.24.**

CPT code 99070 on 12-23-03 was denied as 09 – the provider did not identify the service or materials supplied sufficiently. The requestor did provide documentation of the supplies used to perform this service. **Recommend reimbursement of \$40.00.**

Neither the carrier nor the requestor provided EOB's for CPT codes 98941, 97032, 97016 or 97035 on 12-24-03. The requestor submitted convincing evidence of carrier receipt of provider's request for an EOB in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's Per Rule 133.307(e)(3)(B). **Recommend reimbursement as outlined below:**

CPT code 98941 – \$33.08  
CPT code 97032 – \$20.00  
CPT code 97016 – \$18.09  
CPT code 97035 – \$15.56

Services after August 1, 2003 must be paid in accordance with Medicare program reimbursement methodologies per Commission Rule 134.202 (c) and 134.202(c)(6). CPT code 97016 on 1-5-04 was paid at \$18.09. The MAR is \$18.40. **Recommend additional reimbursement of \$.28.**

Services after August 1, 2003 must be paid in accordance with Medicare program reimbursement methodologies per Commission Rule 134.202 (c) and 134.202(c)(6). CPT code 97035 on 1-5-04 was paid at \$15.56. The MAR is \$15.84. **Recommend additional reimbursement of \$.20.**

CPT code 99080-73 on 3-4-04, 5-12-04, 6-02-04, 7-2-04 was denied with TD – The report was not properly completed or was submitted in excess of the filing requirements. The requestor did provide the correct 99080-73 reports and theses reports were not reported in excess. **Recommend reimbursement of \$60.00.**

CPT code 97530-59 on 5-5-04 was denied with a ZC – A service has been billed which is mutually exclusive of the other services on the same date. Per rule 133.304 (c) Carrier didn't specify which service this was global to. **Recommend reimbursement of \$36.48.**

CPT code 99212-25 on 5-17-04 was denied with an F – A valid modifier is required. Per Ingenix Encoder Pro, "25" is a valid modifier. **Recommend reimbursement of \$48.99.**

Pursuant to 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees from 11-07-03 through 7-2-04 as outlined above in accordance with Medicare program reimbursement methodologies for dates of service after August 1, 2003 per Commission Rule 134.202 (c) and 134.202(c)(6); plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 21<sup>st</sup> day of January 2005.

Donna Auby  
Medical Dispute Resolution Officer  
Medical Review Division

Enclosure: IRO decision

December 20, 2004

TEXAS WORKERS COMP. COMMISSION  
AUSTIN, TX 78744-1609

CLAIMANT:

EMPLOYEE:

POLICY: M5-05-0824-01

CLIENT TRACKING NUMBER: M5-05-0824-01/5278

#### AMMENDED REVIEW

Medical Review Institute of America (MRIOA) has been certified by the Texas Department of Insurance as an Independent Review Organization (IRO). The Texas Workers Compensation Commission has assigned the above mentioned case to MRIOA for independent review in accordance with TWCC Rule 133 which provides for medical dispute resolution by an IRO.

MRIOA has performed an independent review of the case in question to determine if the adverse determination was appropriate. In performing this review all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed. Itemization of this information will follow.

The independent review was performed by a peer of the treating provider for this patient. The reviewer in this case is on the TWCC approved doctor list (ADL). The reviewer has signed a statement indicating they have no known conflicts of interest existing between themselves and the treating doctors/providers for the patient in question or any of the doctors/providers who reviewed the case prior to the referral to MRIOA for independent review.

#### **Records Received:**

##### Records received from the State:

1. Notification of IRO Assignment, 12/7/04
2. Letter from TWCC, 12/7/04
3. Medical Dispute Resolution Request/Response form
4. Request for reconsideration, Southeast Health Services
5. Carrier EOBs

##### Records from Requestor:

1. Chiropractic treating doctor office notes and examinations, 205 pages
2. Consultation, Richard S. Levy, MD, 3/26/04
3. Office notes, Richard S. Levy, MD, 4/20/04, 4/23/04, 5/4/04, 5/18/04, 8/17/04, 6/11/04
4. Letter, Richard S. Levy, MD, 8/17/04
5. Letter from Todd Tkach, 8/12/04
6. Radiographic reports, MRI reports, 11/11/03, 11/25/03, 12/31/03
7. Interim FCE's, 10/13/04
8. Records from Charles Willis II, MD 11/18/03, 12/16/03, 4/2/04, 4/27/04
9. Prescription, 11/18/03, Dr. Willis
10. Copies of completed TWCC-73s

11. Designated doctor examination, Gwen Fields, MD, 11/4/03
12. Functional Capacity Evaluation, 2/2/04
13. Letter from Texas Mutual, 4/6/04
14. Initial FCE, 1/14/04
15. Treatment plans, 9/20/04, 4/27/04, 1/12/04, 8/9/04, 7/5/04, 5/25/04
16. TWCC-69 Report of Medical Evaluation, 4/7/04
17. Examination and report, Phillip Osborne, MD, 2/2/04
18. Physical demand analysis
19. Work conditioning daily notes
20. Required medical examination report
21. Letter of Clarification, Gwen Fields, MD, 6/9/04
22. EMG/NCV report, 12/23/03
23. Texas Worker's Compensation Status reports, 10/1/04, 8/9/04, 7/2/04, 6/24/04, 5/12/04, 2/10/04, 12/10/03, 11/6/03, 6/2/04, 3/29/04, 3/4/04

### **Summary of Treatment/Case History:**

Patient is a 36-year-old deliveryman who, on \_\_\_\_, was proceeding through an intersection when another vehicle from his right suddenly ran a red light and struck him in a "T-bone" fashion on the right rear quarter panel of his truck, injuring his cervical, thoracic and lumbar spines, as well as his left shoulder. He eventually presented to a doctor of chiropractic for conservative care, including chiropractic and physical therapy, but his response was limited. He was referred to a medical doctor who added prescription medications, but the response was still limited. On 04/20/04, he underwent left shoulder arthroscopic repair of his rotator cuff, followed by post-operative physical therapy.

### **Questions for Review:**

1. Were the manual therapy technique (#97140-59), unspecified medicine procedures (#97139), motor NCV testing, without F-wave studies (#95900), motor NCV testing, with F-wave studies (#95903), sensory NCV studies (#95904), and needle electromyography studies (#95861) from 11/12/03 through 12/23/03 medically necessary to treat this patient's injury?

### **Conclusion/Partial Decision to Certify:**

The manual therapy technique (#97140-59) performed on 11/12/03 is certified as medically necessary, as are the electrodiagnostic tests performed on 12/23/03 (#95900, #95903, #95904, #95861). The unspecified medicine procedures (#97139) are not certified.

**Rationale:** In this case, the medical records submitted adequately documented that a compensable injury to the cervical, thoracic and lumbar spines as well as the left shoulder occurred. In addition, the examination findings adequately documented the presence of decreased range of motion and muscular spasticity. Therefore, the performance of manual therapy, specifically myofascial release, was supported as medically necessary.

In addition, the electrodiagnostic testing was medically necessary. According to the Milliman Care Guidelines (ref. 1), this type of testing is indicated:

- "...after a minimum of 3 weeks after any nerve injury for ANY ONE of the following:

- Differentiation of other nerve disorders, such as peripheral neuropathy, peripheral nerve entrapment, diabetes, or demyelinating disease, from nerve root entrapment or myelopathy when diagnosis is unclear with imaging or surgery is being considered
- When nerve root symptoms do not match imaging studies, especially with multiple disk protrusions
- Assessment of the severity of axonal damage when positive findings present on neurologic exam, thereby giving a better idea of prognosis for improvement.”

According to a review of the medical records submitted, these criteria were met and as such, the procedures were medically necessary.

However, insofar as the unspecified manual medicine procedure (#97139) was concerned, the medical necessity for this procedure was not adequately supported in the medical records. According to CPT (ref. 2), this service is a time-based procedure, but the *mere passage of time in and of itself* is not an appropriate reporting of this code. (Rather, its appropriate utilization is to report procedures that are otherwise not specified in CPT.) Yet, that was the basis on which the treating doctor used to justify his medical necessity rationale. Specifically, in the Request for Reconsideration letter he supplied, it was stated, “Due to multiple areas of injury, the session exceeded the typical 45 minutes.”

However, even if code #97139 were reportable based solely on elapsed time, the performance of this service was further unsupported because the daily treatment notes that corresponded to the dates where this service was rendered (11/17/03, 11/18/03 and 12/12/03) failed to document time, and failed to even “check” that this service was rendered.

#### References Used in Support of Decision:

1. Milliman Care Guidelines, *Ambulatory Care* 8th Edition. Copyright © 1996, 1997, 1999, 2001, 2002 Milliman USA, Inc
2. *CPT 2004: Physician's Current Procedural Terminology, Fourth Edition, Revised*. (American Medical Association, Chicago, IL 1999), “97139 DOP unlisted therapeutic procedure (specify)”

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This review was provided by a chiropractor who is licensed in Texas, certified by the National Board of Chiropractic Examiners, is a member of the American Chiropractic Association and has several years of licensing board experience. This reviewer has given numerous presentations with their field of specialty. This reviewer has been in continuous active practice for over twenty years.

MRloA is forwarding this decision by mail, and in the case of time sensitive matters by facsimile, a copy of this finding to the treating provider, payor and/or URA, patient and the TWCC.

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The written opinions provided by MRloA represent the opinions of the physician reviewers and clinical advisors who reviewed the case. These case review opinions are provided in good faith, based on the medical records and information submitted to MRloA for review, the published scientific medical literature, and other relevant information such as that available through federal agencies, institutes and professional associations. Medical Review Institute of America assumes no liability for the opinions of its contracted physicians and/or clinician advisors. The health plan, organization or other party authorizing this case review agrees to hold MRloA harmless for any and all claims which may arise as a result of this case review. The health plan, organization or other third party requesting or authorizing this review is responsible for policy interpretation and for the final determination made regarding coverage and/or eligibility for this case.

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